

# ANNUAL SCHEDULE OF BENEFITS

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## MEDICAL PLAN

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**Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315**  
**www.bluecrossmontana.com**

**New West Health Plan • 1-800-290-3657 or 457-2200**  
**www.newwesthealth.com**

**Peak Health Plan • 1-866-368-7325**  
**www.healthinfontmt.com**

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## MEDICAL RATES

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### Monthly and Per Paycheck Premiums

	<b>New West</b>	<b>Blue Choice</b>	<b>Traditional</b>	<b>Peak</b>
Employee	\$526/\$263	\$552/\$276	\$590/\$295	\$624/\$312
Employee & spouse	\$691/\$345	\$710/\$355	\$814/\$407	\$820/\$410
Employee & children	\$606/\$303	\$622/\$311	\$712/\$356	\$718/\$359
Employee & family	\$704/\$352	\$722/\$361	\$830/\$415	\$836/\$418
Joint Core	\$554/\$277	\$568/\$284	\$646/\$323	\$654/\$327

## MEDICAL PLAN COSTS

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### Annual Deductible

*(Applies to all services unless noted or a co-payment is indicated)*

### Coinsurance Percentages (% of allowed charges member pays)

General

Preferred Facility Services *(See pages 39-40 for a list of preferred/non-preferred facilities)*

Non-Preferred Facility Services

### Annual Out-of-Pocket Maximums

*(Maximum coinsurance paid in the year; excludes deductibles and copayments)*

You pay deductible and coinsurance on allowable charges (see glossary on page 7).

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## MEDICAL PLAN COSTS

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### Hospital Inpatient Services\*

*\*Pre-certification of non-emergency hospitalization is strongly recommended & required by some plans - see plan descriptions*

Room Charges

Ancillary Services\*

Surgical Services\*

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### Hospital Outpatient and Surgical Center Services\*

# BENEFIT YEAR 2009

## NON-MEDICARE MEDICAL RATES (under age 65)

Monthly Premiums	New West	Blue Choice	Traditional	Peak
Retiree	\$526	\$552	\$590	\$624
Retiree & spouse	\$691	\$710	\$814	\$820
Retiree & children	\$606	\$622	\$712	\$718
Retiree & family	\$704	\$722	\$830	\$836
Retiree & Medicare spouse	\$596	\$612	\$700	\$706
Retiree & Medicare spouse and child	\$626	\$642	\$736	\$742

## MEDICARE MEDICAL RATES (age 65+)

Monthly Premiums	New West	Blue Choice	Traditional	Peak
Medicare retiree	\$182	\$196	\$218	\$224
Medicare retiree & spouse	\$392	\$400	\$454	\$460
Medicare retiree & children	\$335	\$342	\$386	\$392
Medicare retiree & family	\$413	\$422	\$480	\$486
Medicare retiree & Medicare spouse	\$347	\$354	\$400	\$406
Medicare retiree & Medicare spouse & family	\$372	\$378	\$430	\$436

### TRADITIONAL PLAN

Administered by BCBS of MT

### MANAGED CARE BENEFIT PLANS

BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT

NEW WEST - Administered by New West Health Plan

PEAK - Administered by Peak Health Plan

#### Benefits

\$600/Member  
\$1,800/Family



25%  
20%  
35%

Average of \$2,500/Member  
(20% - 35% of \$10,000 in allowable charges)

Average of \$5,000/Family  
(20% - 35% of \$20,000 in allowable charges)

#### Member Coinsurance:

20% - 35%

20% - 35%

20% - 35%

20% - 35%

#### In-Network Benefits

\$425/Member  
\$850/Family



25%

\$2,000/Member  
\$4,000/Family

#### Member Coinsurance/Copayment:

25%

25%

25%

25%

#### Out-of-Network Benefits

Separate \$550/Member  
Separate \$1,100/Family

35%

Separate \$2,000/Member  
Separate \$4,000/Family

#### Member Coinsurance:

35%

35%

35%

35%

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## MEDICAL PLAN SERVICES

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### Physician/Professional Services (not listed elsewhere)

Office Visits

Inpatient Physician Services\*

Lab/Diagnostic/Injectibles/Miscellaneous Charges\*

### Emergency Services

Ambulance Services for Medical Emergency

Emergency Room (*If there is an inpatient emergency admission, see plan description for authorizing follow up care.*)

Hospital Charges

Professional/Ancillary Charges

### Urgent Care Services

Facility/Professional Charges

Ancillary - Lab/Diagnostic/Surgical Charges

### Maternity Services

Hospital Charges\*

Physician Charges (including delivery, pre and post-natal office visits) and lab charges\*

Ultrasounds\*

### Routine Newborn Care

Inpatient Hospital Charges

### Preventive Services (see plan descriptions for what services are covered and when)

Adult Exams and Tests

Adult Immunizations (such as Pneumonia and Flu)

Allergy Shots

Child Checkups and Immunizations

### Mental Health Services

Inpatient Services\*

**Max:** One inpatient day may be exchanged for two partial hospital days.

Outpatient Services

With EAP counselor referral

With NO EAP counselor referral

# BENEFIT YEAR 2009

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
25% (no deductible for first two non-routine office visits)	\$15/visit (covers office visit charges only)	35%
25%	25%	35%
25%	25% (no deductible on injectibles without an office visit)	35%
25%	\$100 copay	\$100 copay
20%-35%	\$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)	\$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)
25%	25%	25%
25%	\$25/visit	\$25/visit
25%	25%	25%
20% - 35%	25%	35%
25%	0% (no deductible) with enrollment in prenatal program in first trimester of pregnancy; 25% otherwise	35%
25%	25% (waived on first ultrasound if member enrolls in prenatal program as described above)	35%
20% - 35% (no deductible)	25% (no deductible)	35%
25% (no deductible) <b>Max:</b> 2 bone density tests/lifetime <b>Max:</b> \$500 for colonoscopy, sigmoidoscopy, or proctoscopy	\$15/visit (including specified labs) 0% (no deductible) for periodic mammograms 25% for periodic bone density scans, EKG sigmoidoscopies, double contrast barium enemas, proctoscopies & colonoscopies	35% (plan pays \$75.00 for periodic mammograms - no deductible)
\$50 Max (no deductible)	\$15 with office visit 25% (no deductible) without office visit up to \$10	35%
25% (no deductible)	\$15 with office visit 25% (no deductible) without office visit up to \$10	35%
25% (no deductible) 0% (no deductible for County Health Department through age 7)	\$15/visit <b>Max:</b> Schedule recommended by US Department of Health & Human Services	35%
20% - 35% <b>Max:</b> 21 days (No max for severe conditions)	25% <b>Max:</b> 21 days/yr (No max for severe conditions)	35% <b>Max:</b> 21 days/yr (No max for severe conditions)
25% <b>Max:</b> 40 visits/yr (No max for severe conditions)	\$15/visit <b>Max:</b> 30 visits/yr (No max for severe conditions)	35% <b>Max:</b> 30 visits/yr (No max for severe conditions)
50% <b>Max:</b> 20 visits/yr (No max for severe conditions)	\$15/visit <b>Max:</b> 30 visits/yr (No max for severe conditions)	35% <b>Max:</b> 30 visits/yr (No max for severe conditions)

# ANNUAL SCHEDULE OF BENEFITS

## MEDICAL PLAN SERVICES

### Chemical Dependency Services

Inpatient Services\*

*(Inpatient services must be certified. Pre-certification is strongly recommended.)*

Outpatient Services\*

With EAP counselor referral

With NO EAP counselor referral

\*\*Dollar max for all Chemical Dependency Services: Combined inpatient/outpatient max of \$6,000/year; \$12,000/lifetime; \$2,000/year after max is met.

### Rehabilitative Services - Physical, Occupational, Cardiac, Pulmonary, and Speech Therapy\*

Inpatient Services\*

Outpatient Services

### Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

### Extended Care Services

Home Health Care\*

Hospice\*

Skilled Nursing\*

### Miscellaneous Services

Disease Process Education & Dietary/Nutritional Counseling

Durable Medical Equipment, Appliances, and Orthotics\* *(Prior authorization required for amounts >\$1,000)*

PKU Supplies

Obesity Management\* *(All plans require prior authorization)*

TMJ Treatment\* *(All plans require prior authorization)*

Infertility Treatment\* *(All plans require prior authorization)*

Bariatric Benefit\* *(see page 16 for more details - requires prior authorization)*

### Organ Transplants *(Must be certified. Pre-certification is strongly recommended.)*

Transplant Services (including out-of-state travel)\*

# BENEFIT YEAR 2009

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
20%-35% Max: Dollar Limit**	25% Max: Dollar Limit**	35% Max: Dollar Limit**
25% Max: 40 visits and Dollar Limit**	\$15/visit Max: Dollar Limit**	35% Max: Dollar Limit**
50% Max: 20 visits and Dollar Limit**	\$15/visit Max: Dollar Limit**	35% Max: Dollar Limit**
20% - 35% Max: 60 days/yr	25% Max: 60 days/yr	35% Max: 60 days/yr
20% - 35% Max: \$2,000/year for all outpatient (\$10,000/year for prior-auth. conditions)	\$15/visit Max: 30 visits/yr	35% Max: 30 visits/yr
25% (plus charges over \$30/visit)	Not covered	Not covered
25% (plus charges over \$30/visit)	Not covered	Not covered
25% (plus charges over \$30/visit) Max: 25 visits in any combination	\$15/visit Max: 20 visits/yr	35% Max: 20 visits/yr
25% Max: 70 days/yr	\$15/visit Max: 30 visits/yr	35% Max: 30 visits/yr
25% (20% - 35% if hospital-based) Max: 6 months	25% Max: 6 months	35% Max: 6 months
25% (20% - 35% if hospital-based) Max: 70 days/yr	25% Max: 30 days/yr	35% Max: 30 days/yr
20% - 35% Max: \$250/yr	0% (no deductible) Max: \$250/yr	35% Max: \$250/yr
25% Max: \$100 for foot orthotics (per foot)	25% (Not applied to out-of-pocket max) Max: \$100 for foot orthotics (per foot)	35% (not applied to out-of-pocket max) Max: \$100 for foot orthotics (per foot)
25%	25% (no deductible)	35%
25%	25% non-surgical only	Not covered
25%	25% surgical only	Not covered
25% 1 in-vitro attempt per lifetime	25% Max: 3 artificial inseminations/lifetime	Not covered
25% Lifetime Max: \$35,000	Not covered	Not covered
25% • Liver: \$200,000 • Heart: \$120,000 • Lung: \$160,000 • Heart/Lung: \$160,000 • Bone Marrow: \$160,000 • Pancreas: \$68,000 • Cornea/Kidney: No maximum	25% \$500,000 lifetime maximum with \$5,000 of the maximum available for travel to and from the facility.	Not covered

# MEDICAL INSURANCE PLANS - 2009

## Administered by:

Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315 • [www.bluecrossmontana.com](http://www.bluecrossmontana.com)

New West Health Plan • 1-800-290-3657 or 457-2200 • [www.newwesthealth.com](http://www.newwesthealth.com)

Peak Health • 1-866-368-7325 • [www.healthinfonetmt.com](http://www.healthinfonetmt.com)

## WHO IS ELIGIBLE?

Employees, Legislators, Retirees, COBRA members and their dependents (spouse, domestic partner, children) are eligible for the medical plan. Employees are required to be enrolled in medical coverage unless they waive the entire benefit package. For more information about dependent eligibility, see page 18.



### CLICK ON IT!

Learn more about the participating providers by visiting the plan's web sites at:

[www.bluecrossmontana.com](http://www.bluecrossmontana.com)

[www.newwesthealth.com](http://www.newwesthealth.com)

[www.healthinfonetmt.com](http://www.healthinfonetmt.com)

## HOW TO DECIDE THE RIGHT PLAN FOR YOU

1. Read about each plan in the General Information section on this page.
2. Review/compare each plan's costs, deductibles and services in the Schedule of Benefits starting on page 10 or through the SOME information resource available on the MINE or [benefits.mt.gov](http://benefits.mt.gov).
3. Review your typical health care needs compared with the structure of the plans.
4. If you are considering a managed care plan, review the Managed Care Areas section on pages 36-38.
5. Determine which plan will work best for your personal situation.
6. If you choose to change plans for the 2009 benefit year, indicate your choice on the *Individual/Retiree Benefits Statement* or on-line as indicated on pages 4-5.

## GENERAL INFORMATION

The State of Montana offers an indemnity insurance plan and three managed care plans to choose from:

- **Traditional Indemnity Plan**
- **Blue Choice Plan**
- **New West Health Plan**
- **Peak Health Plan**

## LIFETIME MAXIMUM

The lifetime maximum (the maximum the plan pays) per person on the plan is \$2 million.

## TRADITIONAL PLAN

The Traditional indemnity plan is administered by Blue Cross and Blue Shield of Montana (BCBS), which processes claims and payments, provides customer service and notices to members in the form of an Explanation of Benefits (EOB). BCBS also contracts with health care providers to offer plan members a provider network — providers who have agreed to accept certain plan allowances.

## How The Plan Works

Plan members obtain medical services from a covered health care provider. If the provider is a BCBS provider, they will submit a claim for the plan member. BCBS will then process the claim and send an EOB to the plan member, indicating their payment responsibilities (deductible and/

or coinsurance costs) to the provider. The Plan then pays the remaining allowable charges, which the provider accepts as full payment. Please verify a provider is currently participating by calling BCBS or checking their website.

If the provider is not a BCBS provider, you may be required to pay the entire fee and file a claim for reimbursement. There may be unallowed charges which you will have to pay.

## Bariatric Benefit

This benefit is available only on the Traditional plan. To qualify, the member must be on the State plan for 18 months, have a body mass index over 40, participate in the *Why Weight* program (page 28) and meet medical necessity requirements for the procedure. For benefit coverage information, see pages 14 & 15.

## Preferred Facility Services

Plan members may obtain covered medical services from any covered hospital. However, certain hospitals and surgical centers offer services for members on the Traditional plan that are subject to lower coinsurance rates. Please refer to the Participating Facilities section on page 39 for a list of these facilities. For your protection, it is strongly recommended to pre-certify all inpatient hospital services by calling your

plan's customer service phone number, listed at the top of this page.

## Out-of-State Services

The Blue Card Program lets plan members tap into BCBS plan networks in other states. If the out-of-state BCBS plan includes "hold harmless" provisions, the member will not be responsible for balances above the allowable amount.

## MANAGED CARE PLANS

Blue Choice, New West Health Plan, and Peak Health Plan are managed care plans offered through the Montana Association of Health Care Purchasers, a purchasing pool of which the State is a member. The plans generally provide the same package of benefits, but there are differences in premium costs, providers and requirements for receiving services.

## How They Work

The benefits of managed care plans depend on the health care provider the member uses. When a network provider is used, the in-network benefits apply. When an out-of-network provider is used, out-of-network benefits apply (unless a required plan authorization is obtained).

## In-Network Benefits

Anytime a network provider is used, the in-network (highest level of benefit) is



applied. For a complete listing of all in-network providers including specialists, check the plan administrator's website or call their Customer Service number. An authorization is not required for the plan member to see an in-network specialist. Plan authorizations **are** required to see an out-of-network specialist and still receive the plan's in-network benefits.

### Out-of-Network Benefits

When plan members obtain services from providers who are not part of the plan's network, without a required authorization, costs will be more because a separate and higher deductible, a higher coinsurance rate, and a separate out-of-pocket maximum apply.

To obtain an authorization to see an out-of-network provider from New West or Blue Choice plans, the member must contact the plan administrator directly.



Referrals for the Peak plan are obtained through your Primary Care Provider.

### Major Plan Differences

The major difference in the managed care plans are the participating providers and premium costs.

Check which providers participate by visiting the plan websites listed on page 16.

### Out-of-State Services

Plan members may receive in-network benefits for medical services in other states for a medical emergency. For non-emergency services out-of-state, please contact your plan administrator for specific provider network information.

### SERVICE AREAS

The Traditional Plan is available to members living anywhere in Montana or throughout the world. The plan includes services of any covered providers. However, providers who are not BCBS member providers may charge more for a service than the plan allows, leaving you responsible for paying the difference.

The managed care plans – Blue Choice, New West Health Plan, and Peak Health Plan – are available to members living in certain areas in Montana. Please see pages 36-38 for a complete listing of covered zip codes for each plan.

### Blue Choice

This plan is available in most of Western Montana and many other towns including Bozeman, Billings, Great Falls, and Havre.

### New West Health Plan

This plan is available in most of Western Montana and many other towns including Bozeman, Billings, Great Falls, Havre, Libby, Miles City and now in Lewistown.



### Peak Health Plan

This plan is available to members in Billings, Butte, Deer Lodge, and nearby communities.

## MEDICAL PLAN COST COMPARISONS

This cost comparison shows how each medical plan would process the same service and what costs the plan member would be responsible for paying. The example is **cumulative** with respect to deductibles and coinsurance. The first line of each example shows the total costs to the member. The next three lines show how that cost is divided between copays, costs applied to the deductible, and coinsurance costs. It does not include premium costs, which are outlined on pages 10 & 11. These examples assume the services were for one member. This is simply an example for ease of plan comparison and is not a guarantee that similar services will process identically.

\*First two office visits are exempt from the deductible for this comparison.

Sample Services	TRADITIONAL		MANAGED CARE PLANS	
	Allowable Charge		In-Network	Out-of-Network
Office visits 1, 2, & 3 (\$50 each)	\$150	<b>You pay →</b> \$75	\$45	\$150
Copay costs			\$45 (\$15/each)	
Costs applied to deductible		\$50*		\$150
Coinsurance costs		\$25		
Lab charges with office visit 1	\$75	<b>You pay →</b> \$75	\$75	\$75
Copay costs				
Costs applied to deductible		\$75	\$75	\$75
Coinsurance costs				
Specialist Visit (i.e. dermatologist)	\$200	<b>You pay →</b> \$200	\$15	\$200
Copay costs			\$15	
Costs applied to deductible		\$200		\$200
Coinsurance costs				
Preferred hospital inpatient	\$8,500	<b>You pay →</b> \$1,920	\$2,350	\$2,125
Copay costs				
Costs applied to deductible		\$275	\$350	\$125
Coinsurance costs		\$1,645	\$2,000**	\$2,000**

\*\*coinsurance out-of-pocket maximum